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**Notice of Independent Medical Review Determination**

Dated: 10/8/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]  
5/23/2013

1/17/2013

6/10/2013

CM13-0000631

- 1) MAXIMUS Federal Services, Inc. has determined the request for an AP/lateral x-ray of the left knee **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an AP/lateral x-ray of the lumbar spine **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a CT scan of the right elbow **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/10/2013 disputing the Utilization Review Denial dated 5/23/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for an AP/lateral x-ray of the left knee **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an AP/lateral x-ray of the lumbar spine **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a CT scan of the right elbow **is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Preventative Medicine and Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The Expert Reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and treatments and/or services at issue.

### **Case Summary:**

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 2, 2013:

“This 52-year-old male was injured on 1/17/13. The mechanism of injury occurred when he slipped on ice and twisted his left hand and landed on his right elbow and shoulder. The diagnoses were: low back sprain, left knee sprain, right shoulder sprain, and right elbow contusion. He continued to report pain in his low back, and knee. He had mild patellofemoral degenerative joint disease and prominent spurring of the medial femoral condyle. On 5/1/13, he saw Dr. [REDACTED] and he had crepitus over the radial hood with motion, with a clunk on range of motion (ROM). He had Full ROM. His shoulder ROM was full and unrestricted, and there were no focal neurologic deficits. There was some tenderness of the subacromial area with no significant atrophy. There was prepatellar bursal inflammation and the knee was otherwise unremarkable. There was tenderness over the anterior knee, the lumbar spine was not examined. Additional X-rays were ordered for the right elbow and left knee. A CT scan of the elbow was also recommended. On 5/8/13, He saw Dr. [REDACTED] and the elbow contusion has resolved. His left knee was still symptomatic, and the shoulder sprain has resolved. The right elbow exam was unremarkable. His gait was normal. He still had burning knee pain. The lumbar spine region was tender with no other significant findings noted.”

### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review dated 6/10/2013
- Utilization Review Determination provided by [REDACTED] dated 5/23/2013
- Medical Records from 1/17/2013 through 6/15/2013
- Medical Treatment Utilization Schedule

### **1) Regarding the request for an AP/lateral x-ray of the left knee:**

#### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Knee Complaints, Chapter 13, pages 341-343, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG) Current Version, Knee Chapter, Radiography section, which is a medical treatment guideline that is not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer determined that the MTUS does not specifically address the topic of plain film imaging for the issue in dispute. The Expert Reviewer relied on the ACOEM Guidelines, 3<sup>rd</sup> Edition, Knee Chapter, Table 8, which is a medical treatment guideline that is not part of the MTUS.

#### Rationale for the Decision:

The employee was injured on 1/17/2013 and is being treated for a humeral fracture, an elbow contusion, knee pain, low back pain, and shoulder pain. The employee has been treated with analgesic medications and at least six sessions of physical therapy. The records dated 5/1/2013 document concern of a foreign body in the left knee. On 6/10/2013, the employee reported 80% improvement of the right elbow with continued left knee pain. A request was submitted for an AP/lateral x-ray of the left knee.

The ACOEM Guidelines state that x-rays may be appropriate to evaluate for infection, osteomyelitis, and foreign bodies. The provider noted on 5/1/2013 concern for presence of a foreign body in the employee's left knee on x-ray. While this is not confirmed on the radiology report, the employee has persistent symptoms of knee pain as noted on the clinic note dated 6/10/2013. Since the guidelines recommend x-rays to rule out concern for presence of a foreign body, the requested A/P and lateral x-ray of the left knee is indicated to exclude the presence of foreign bodies. The request for an AP/lateral x-ray of the left knee is **medically necessary and appropriate.**

## 2) Regarding the request for an AP/lateral x-ray of the lumbar spine:

### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition, (2004), Low Back Complaints, Chapter 12, page 303-305, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the ACOEM Guidelines, Chapter 12, Table 12-7, which is part of the MTUS.

### Rationale for the Decision:

The employee was injured on 1/17/2013 and is being treated for a humeral fracture, an elbow contusion, knee pain, low back pain, and shoulder pain. The employee has been treated with analgesic medications and at least six sessions of physical therapy. The records dated 5/1/2013 document concern of a foreign body in the left knee. On 6/10/2013, the employee reported 80% improvement of the right elbow with continued left knee pain. A request was submitted for an AP/lateral x-ray of the lumbar spine.

The ACOEM Guidelines indicate that lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. The guidelines note that plain film x-rays are scored a 0/4 in their ability to identify and define low back pain pathology. In this case, the progress note dated 6/10/2013 documented an operating diagnosis of lumbar strain. As suggested by the guidelines, plain films x-rays would be of no benefit in identifying and/or defying a lumbar strain. The request for an AP/lateral x-ray of the lumbar spine **is not medically necessary and appropriate.**

## 3) Regarding the request for a CT scan of the right elbow:

### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines, Elbow Chapter, CT section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition (2007 revision), Elbow Chapter, pages 23-24 and 42-43, which are part of the MTUS.

### Rationale for the Decision:

The employee was injured on 1/17/2013 and is being treated for a humeral fracture, an elbow contusion, knee pain, low back pain, and shoulder pain. The employee has been treated with analgesic medications and at least six sessions of physical therapy. The records dated 5/1/2013 document concern of a foreign body in the left knee. On 6/10/2013, the employee reported 80% improvement of

the right elbow with continued left knee pain. A request was submitted for a CT scan of the right elbow.

The ACOEM Guidelines indicate that CT imaging may be appropriate for patients who have demonstrated failure to progress in a strengthening program and/or cases in which the imaging study results would substantially change or alter the treatment plan. The records submitted and reviewed do not include evidence that imaging studies would alter the employee's treatment plan. The guidelines state that non-displaced radial head fractures can be splinted and/or immobilized for three to seven days following the injury. It has been several months since the date of injury. CT scanning would not alter the treatment plan or support further immobilization. Therefore, the request for a CT scan of the right elbow **is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.